

CAPT WEBINAR:

Leveraging PDMP Data to Support Prevention Planning Webinar Series

TRANSCRIPT

Full Title: Part 2: Using Prescription Drug Monitoring Programs across SAMHSA's Strategic Prevention Framework

Date: January 26, 2017

Facilitator: Sarah Ivan, Project Associate, SAMHSA's CAPT

Presenters: Sandeep Kasat, Associate Director of Epidemiology, SAMHSA's CAPT; Meelee Kim, Research Associate, Institute for Behavioral Health, Brandeis University; Thomas Clark, Research Associate, Institute for Behavioral Health, Brandeis University

[Sarah Ivan]: [Referring to the poll question] Feel free to answer about which Strategic Prevention Framework (SPF) step you think the Prescription Drug Monitoring Program (PDMP) data would be most use. You can select which options you think are appropriate. There are several options you can choose from on the left.

Hello everyone. And we will be getting started in just a few minutes. If you have not done so already, please select a response option to the poll. You can choose more than one step if you'd like. And the question is just to answer at which SPF step you think PDMP data would be most useful.

Hello everyone. Welcome. We will be getting started in a few minutes and many of you have started to answer the poll question on which SPF step you think could be most useful, and if you have not done so already, please select your response or responses to our—our poll question. So, for those of you who are familiar with SAMHSA's Strategic Prevention Framework, at which step or steps do you think PDMP data are useful.

We have a few more people joining us. Welcome to *Using Prescription Drug Monitoring Programs Across SAMHSA's Strategic Prevention Framework*. And thank you for those who have started to answer the poll question and I see that many of you have selected Assessment or Evaluation. Thank you so much for your responses and for those of you who have not yet responded please feel free to add your response to the poll.

Hello everyone and welcome to *Using Prescription Drug Monitoring Programs Across SAMHSA's Strategic Prevention Framework*. We appreciate your responses to the poll question we have up right now. If you haven't answered already, please feel free to include

your answer. I see a lot of people have already started to input their responses. Many of you are saying that Assessment is a really great place to use some of the PDMP data.

Hello everyone and welcome to *Using Prescription Drug Monitoring Programs Across SAMHSA's Strategic Prevention Framework*. We have a poll question up right now and so for those of you who are familiar with SAMHSA Strategic Prevention Framework, at which step or steps do you think PDMP data are useful and you can select more than one if you'd like and I see many of you have already started to respond to the poll, so thank you for your responses. I am just going to give it one more minute for some additional people to—to attend.

Hello everyone and welcome to our call today on *Using Prescription Drug Monitoring Programs Across SAMHSA's Strategic Prevention Framework* and we have a poll question up right now. For those of you who have not answered, we'd appreciate it if you could include your response and we will get started in just another minute. And I see in the chat one of our presenters, Sandeep: "Assessment is winning; Evaluation is close."

Alright. So, we—I think it's about time for us to get started and we have a lot of grantees represented here which is great. We are so happy to have everybody. Today's webinar is titled *Using Prescription Drug Monitoring Programs Across SAMHSA's Strategic Prevention Framework*. We are going to be building off of the information from our last webinar focused on PDMPs and applying how Prescription Drug Monitoring Programs can be utilized at each SPF step.

And, my name is Sara Ivan and I'm a Project Associate with National and Cohort-Based Services at the CAPT and I'm going to be facilitating today's webinar and as a reminder we are recording today's call so that any of your colleagues who may have missed the event can tune in for the archived version. We will also be posting all of the materials from today's webinar on CAPT Connect for your reference later and also as a reminder, this training was developed under SAMHSA's CAPT task order and it is for training and peer sharing purposes only.

And we have several learning objectives for today's webinar. At the conclusion of the webinar you should be able to identify initial steps for preparing to use PDMP data to inform prevention effort, describe opportunities that you can use PDMP data throughout the SPF in order to—in order for—to prevent the nonmedical use of prescription drugs, and finally to be able to provide specific examples of how PDMP data has been used throughout the SPF process.

And now I'd like to introduce our presenters, and we have three experts who are—will be presenting today. Meelee Kim is a research associate at Brandeis University's Institute for Behavioral Health and Ms. Kim conducts research and evaluation on community and state level programs aimed to prevent substance use and misuse and other health and behavioral health problems. She is currently working on projects, exploring opportunities for using

Prescription Drug Monitoring Programs to evaluate initiatives to facilitate safer prescribing of controlled substances.

Thomas Clark is also a research associate at Brandeis University's Institute for Behavioral Health and Mr. Clark has extensive experience in managing, evaluating, and researching prescription drug monitoring programs. His current work includes determining prescription drug monitoring program best practices, identifying innovative uses of prescription drug monitoring program data in a broad range of applications, and developing the evidence base for Prescription Drug Monitoring Program effectiveness.

And, we also welcome Sandeep Kasat who is the Associate Director of Epidemiology at the CAPT and he is responsible for producing and updating the CAPT epidemiological tools and data-related projects. He also provides training and technical assistance on using epidemiological data, tools, and products to guide prevention planning and decision-making.

So, welcome to all of our presenters and I wanted to just review a little bit about our PDMP webinar series, and you'll refer—throughout this presentation you'll hear me refer to Prescription Drug Monitoring Programs, or PDMPs, and during our last webinar we covered—on January 10th we defined what PDMPs are. It talks about how to use PDMPs to support prevention efforts and referred our attendees to some PDMP resources. This webinar, the overview of PDMPs, is currently on CAPT Connect, so if you any of you missed that webinar please feel free to take a look at that and listen in at your leisure.

And, today, we will review PDMPs across the SPF, and that's our *Using PDMPs Across SAMHSA's Strategic Prevention Framework*, and finally on February 16th we will focus on collaborations with PDMPs and this webinar will provide specific examples from the field on how PDMPs are being utilized.

So, we thank those who have been able to attend this series and we hope you will be able to attend the upcoming webinar. If anybody does have any questions, please do not hesitate to reach out to me and we can put my email address in the chat and it is also included in the—at the end of the presentation.

So, to start, I think I'm going to hand the presentation over to Sandeep to review how you'd prepare to use PDMP data across the SPF.

[Sandeep Kasat]: Thanks, Sara. So before we begin—before we get into the discussion of how to use PDMP data in Strategic Prevention Framework, you may need to do some groundwork before starting with the PDMP data. I like to call it step zero, or building your base, if you will. So, first, the best place probably to start is your state PDMP website which can provide you with the overview of PDMP and legislation in your state and also often provides useful information like your PDMP annual report and links to other useful resources like PDC efforts and guidelines that you may find useful. Once you get familiar with your PDMP, the next step is to connect with the PDMP administrator to make them aware of what your goals and expectations are. You may want to do this by, let's say, inviting your PDMP representation or administrator to your epidemiology cohort group or evaluator

workgroup meetings. Next steps would be to get access to the data or report given what's allowed under your state legislator. Some PDMPs have the data request form online and your PDMP administrator may be able to guide you on how to request PDMP data for your state. However, as we learned during the first webinar, PDMP data can be complex to understand and interpret, so you need to designate someone who is knowledgeable about data to spend some time understanding the data and while that is going on, you may want to talk about—talk to other stakeholders in your state who already use PDMP data or find PDMP useful like the Department of Health or agencies that are working—already working on opioid-related initiatives within your state or substate area and creating this PDMP subgroup, if you will, will help you understand and use PDMP data better and it also minimizes the burden on your PDMPs for data sharing, which are quite often busy with their own work. And also I want to add a quick note that although you need to be thinking about these steps early on, these steps are also weaved in throughout your SPF process and you are already doing that with other priorities in your state, so I just wanted to make a note of that.

With this, I'm going to turn it over to Sara for this polling activity. So, Sara? I don't think we can hear you Sara?

[Sarah Ivan]: Sorry, Sandeep. Thank you. And, so I think next we are going to go into the poll and we'd like to know what other steps you've taken or you plan to take in order to make PDMP data useful, so please feel free to enter your response into the chat. We'd like to hear from everybody. We will just give you a minute or two to think about that on what other steps you may have taken or you plan to take in order to make Prescription Drug Monitoring Program data useful. I see we have a couple of people typing into the chat right now. Now, multiple attendees are typing.

[Sandeep Kasat]: And I'm kind of curious because, you know, assessment and evaluation and then followed by planning was sort of what we got from how states can use PDMP data, Sara, so I'm kind of curious —

[Sarah Ivan]: Yeah.

[Sandeep Kasat]: —that—what steps our grantees have already taken in those areas to make it more useful.

[Sarah Ivan]: Agreed. I think it is going to be really interesting to hear from everybody. So, Irwin says, “I reached out to the state rep for data and hope to include this in our regional needs assessment.”

[Sandeep Kasat]: There you go. Right on.

[Sarah Ivan]: Yep. And, Jane: “Include DCP PDMP administrator as part of our SEOW.” Absolutely. That's definitely important to include people in the process. I see a few more people are typing. Tessa: “We use the data for educating partners and coalition members, as well as using the information to guide us to new collaborators.” Yeah, it can be really

important to—to utilize the data so you are able to make a better case for—for what you are doing.

[Sandeep Kasat]: And that's really good, Tessa. That's like sort of Assessment, as well as Capacity Building of partners and coalitions.

[Sarah Ivan]: And, Tessa, I'd love to hear about some of the—the new collaborators that you maybe have found, if you've found anybody yet. Meghan Hawks: “Measures included in SEOW; work on various grants with PDMP data and include coordinator and prevention and treatment collaborative groups.”

[Sandeep Kasat]: Yep.

[Sarah Ivan]: Excellent. Yeah, it's definitely a great example of—of things that you could do. And, Tessa, yes, we kind of blurred the line for some of the Capacity Building and Assessment. Yeah. Some of these steps really do blend into each other for sure. And if anybody else has any—any other steps you may have taken or—or anything you've planned to do in order to make PDMP more useful, please feel free to—to type it into the chat. We'd love to hear some of these examples, even if you are just planning it—planning it now. I know that some people are in different places and that's totally okay. And Tessa says, “We were able to identify an insurance provider willing to help us fund drug disposal bags for consumers, as well as a few others.” Yeah, you can sometimes find unusual collaborators through these—through these methods, so great job.

[Sandeep Kasat]: Tessa, you are actually touching on strategies with PDMP data.

[Sarah Ivan]: Yeah. Alright. So, thank you so much for everybody for your thoughtful answers and I think I'm going to pass the presentation back over to Sandeep who is going to begin our discussion on how to use PDMP data.

[Sandeep Kasat]: Sure. Thank you, Sara.

[Sarah Ivan]: Thanks everybody.

[Sandeep Kasat]: So, I know that we briefly touched on utility of PDMP data in these Strategic Prevention Framework, or SPF, doing the first webinar. Here, we are going to talk—walk you through SPF steps and identify some state examples of how they have used PDMP data corresponding to each of the SPF steps. So, needs assessment is probably one of the most critical steps in the SPF since this sets you up for what you are doing, going to do in all other steps and especially like most of you selected Assessment as one of the major things you are undertaking right now with the PDMP data. This is where you actually gather epidemiological data from various sources, PDMP being one, and analyze the data to make recommendations about your priorities and target subpopulations. With PDMP data, you can look at most commonly prescribed drugs in your state and also look at patient characteristics like age, gender, and country to find out who is at increased risk.

So, when we look at aggregated PDMP data from the nine prescription behavioral surveillance states, or PBSF states, over the past four years it is probably not a surprise that opioids are the most commonly prescribed drugs, followed by benzodiazepines and stimulants, and based on the number of national reports data and research literature, this is generally representative of prescribing practices of what is going on in the nation as well.

You can also use PDMP data to break each of the drug categories further to find out what specific drug is being prescribed in your state. Here, we see that for PBSF states hydrocodone and oxycodone are the most commonly prescribed opioids. Again, this is consistent with what we see from national reports and research literature and interesting to note that tramadol shows up in 2015. It wasn't there in the previous year since it was added to the control substances lists by DEA in August 2014, so another way PDMP data can help in terms of what specific drugs types you are dealing with here in your state and what is kind of emerging new drug that you want to deal with.

So, since PDMP data doesn't include patient identifiers, you can break the data down by subgroups like age, gender, and county to see who is at higher risk. You can see that for ten PBSF states older adults have the highest prescribing rates and this might make it sort of consistent with national prescribing practices and also opioid-related overdose deaths, which are higher in older adults. But, I do want to mention that it is still important for all of us working in prevention to start early. Since we know that young adults report getting their opioid from their older family members, young adults who start experimenting with these opioids get addicted later and some switch to heroin which is responsible for far more severe consequences and—and it's important to keep in mind that PDMP data does not differentiate between medical and nonmedical use, so what we are seeing here also could be due to the fact that the legitimate medical use since the majority of chronic pain patients also are older adults. So exercise caution while using PDMP data, while looking at PDMP data and the thing to remember that PDMP data is sort of one of these sources that you will be looking at for needs assessment.

Maybe one of the best uses of PDMP data in needs assessment is to identify geographic hot spots and I'm going to turn it over to Meelee who is going to walk us through how California did it in their state.

[Meelee Kim]: Thanks Sandeep. So, as Sandeep mentioned, we are hoping to provide a few examples to showcase how multidisciplinary or cross-sector collaborations have used their state PDMPs as just one source for helping states and local communities prioritize where to target their efforts to prevent nonmedical use of prescription drugs, so in California there is the California Healthcare Foundation that has funded community-level coalitions to implement at one of three priority areas that they have identified which also align with federal efforts, so namely they are looking to support coalitions that are interested in promoting and supporting safer prescribing practices. They are also looking to expand access to medication-assisted treatments and to increase naloxone access. So, since this particular section is about the needs assessment, we wanted to show how PDMP data are being used to help assess what Sandeep called community hotspots.

So we have a couple of maps here that are based on the California PDMP system called CURES and the boundaries that you are seeing are counties and you see here towards the top, patterns where there are within state variation so the darker the color, the higher the opioid prescribing rate. You see a pattern here and I'm going to switch over to the next slide and you'll see a similar pattern and this map is showing rates of high dosage, so high dosage meaning more than 100 mg morphine equivalent. I know the CDC has put the threshold at 90, but this is looking at above 100. And so I know that there are a lot of communities that have included their PDMP administrators into their state epidemiological workgroup and so I'm sure that there are other states that are working at these kinds of measures, but just to illustrate for those states what the PDMP has to offer. And as we've mentioned, PDMP data is just one data source that communities can use in conjunction with other data sources to identify and assess the need and also to identify potential gaps in services, so I'm going to hand it over to Sara to talk about other data sources that can be used.

[Sarah Ivan]: Thanks, Meelee for providing the—the helpful example on how to use PDMP data in Assessment. So there are some limitations to PDMP data and therefore we've included some of the sources of data for NMUPD that prevention practitioners may want to explore during the Assessment Step, so these can be used in conjunction with PDMP data to determine the needs in your community, so many of you might be familiar with these data sources and most of them are national data sets, so you will need to use them to drill down to the community level to see more about your community specifically and, again, these are just to be used in conjunction with your PDMP data to get another sense as to—to what's going on in your specific community.

[Sandeep Kasat]: Sara, I just wanted to add one more point that Tim actually pointed out in the chat box—it's important that we parse out the medication-assisted treatment drugs from the rest of the narcotics, as it could falsely drive up the overall rates and I just wanted to mention that that's a great point and then that speaks to you—like we, as prevention practitioners using other data sources as well and other pieces of information to make sense of PDMP data, so just wanted to address that, that Tim made an excellent point.

[Sarah Ivan]: Absolutely.

[Sandeep Kasat]: And then —

[Sarah Ivan]: Yeah, that's a really excellent point. Yeah, definitely, and these data can definitely help to drill down to that level and help to parse out exactly what is going on in your community and with specific drugs or in specific populations, so great point and it definitely speaks to—to the message we are trying to drill into here.

Alright, and so from here, we are going to move into Capacity Building, so Capacity Building is the second SPF step we are going to address and there are a few ways that you can build capacity. Prescription Drug Monitoring Programs can be used to raise awareness through your state or country profiles, prescriber and/or pharmacy report cards and through

other means. Prescription drug monitoring programs can also foster collaborations between multiple agencies. An example of this is if there is a fee to access PDMP data, agencies may join their efforts together so that they can gain access as a single entity. And, finally, generating reports and data summaries to promote understanding of how Prescription Drug Monitoring Programs function and what their role in prevention can be helpful to building your capacity and so now I'm going to pass the presentation back to Tom to review an example of how PDMPs have been instrumental in building capacity. Alright, Tom.

[Tom Clark]: Thank you, Sara. Good afternoon everybody. Thanks for joining us. Speaking to Tim's point, PDMP data can track buprenorphine. We can look at that separately and, indeed, we've seen an increase in buprenorphine use as efforts—prevention efforts have gone on, so that's a good sign. People getting MAT treatment using buprenorphine.

But, here, what we are going to look at one example of how prescription monitoring data can actually be used in capacity building. This is looking at Project Lazarus in North Carolina. Perhaps some of you have heard of it. It—it was—I don't know that it still is ongoing but it served as a wonderful model of stakeholder collaboration to address prescription drug abuse. It started in Wilkes County, run by Fred R. [?] It started in, I think, 2009, and what they did—what we are going to concentrate here on mostly is PDMP data, but it involved a great—a good deal of stakeholders of different varieties in Wilkes County initially and—but here we will just look at what happened with PDMP data. What they did was they broke out PDMP data by county. County-level data on Prescription Drug Monitoring Program utilization by prescribers. Also prescribing rates as Meelee described in California and also patient risk measures like doctor shopping, multiple provider episodes. So, they had these data broken out by county and also they could look at it by state and what they did was they had local meetings specifically here in Wilkes County originally and presented these data showing stakeholders and community members where Wilkes County was—how it compared with other counties in the state in terms of these PDMP measures and—what they were able to show is that there was great room for improvement in terms of participation in the PDMP and participation in the PDMP is a very important prevention step because the more prescribers use the prescription monitoring program the more—the better prescribing will be and they will be able to detect doctor shopping, overlapping prescriptions, combinations of drugs that are risky, so that's what you want to see is an increase in utilization of the PDMP, so they are able to—by presenting these data they were able to motivate stakeholders in the community to do—to take a concrete action step, namely—well, among many other steps, but again focusing on the PDMP they were able to get stakeholders to contact and educate prescribers about the importance of using the prescription monitoring program. So, it helped to build capacity in this by building motivation in the community to take action and the concrete action step was—one of them was to build participation in the PDMP, get prescribers enrolled and use—and using the program. So, and the outcomes were good. Utilization increased. We saw declines in doctor shopping, less risky prescribing, and ultimately the—the health outcomes were very positive. Over the course of two years, they saw a really dramatic decline in overdoses and deaths in the county attributable to prescription drugs and at the end of 2011 none of the local prescribers

had prescribed any of those prescriptions involved in the overdose deaths that did happen. So, a very strong prevention effort here. Again, PDMP data—we are not the only data by any stretch that were used. There were other efforts as well, including naloxone distribution, but I—I thought this was a very nice example of how PDMP data can be used to—to motivate people to take action in their community.

So, with that, I'll hand it back to Sandeep who will talk about Planning using PDMP data.

[Sandeep Kasat]: Thanks, Tom. And great point about the buprenorphine that you brought up that we could look at the prescribing rates and opioid prescriptions by MAT drugs and see how the age distribution or county or gender distribution looks like, so definitely we will look at that as well.

So, under this step three, which is planning, you would have already looked at—let's say assume that you've looked at your PDMP data, build your capacity to understand the PDMP data and selected your priority and let's say opioids and now looking at some risk and protective factors for opioid use. We do know that over-prescribing or higher dosage as we saw in Meelee's presentation and doctor or pharmacy shopping behavior and dangerous combinations like opioids and benzodiazepines are some of the major risk factors for opioid misuse and overdose and we can get data on these indicators from prescription drug monitoring programs.

For example, Oklahoma looked at their PDMP data to identify where these doctor or pharmacy shopping incidences were happening by county. I should mention that they did a couple of more things to make the PDMP data more useful for their prevention planning. First, they modified the definition of doctor shopping to be more inclusive and identified even borderline cases where they might not cross the threshold of doctor shopping guidelines or pharmacy shopping guidelines according to CDC, but are getting higher than normal supply of opioids, if you will. And they also looked at other data sources like opioid overdose deaths within their counties and mapped it with the doctor or pharmacy shopping behavior to come up with hit map or hot spot and then they looked at, like, county level data for the state of Oklahoma. And these hot spots, now identified areas where opioid overdose deaths were already higher and patients that were engaged in doctor shopping or pharmacy shopping behavior, and what they are currently doing is looking at ways to target prevention resources to these hot spot communities and I should also add that we are going to hear from Oklahoma in our third webinar so definitely tune in for that. They have a lot to offer and they have done a lot of work using PDMP data and also in terms of collaboration and I'm going to turn it over to Sara to know how you can take this kind of information and apply in the next SPF step which is Implementation.

[Sarah Ivan]: Thanks Sandeep, so, yes, the next SPF step is step four, Implementation, and in prevention we can use Prescription Drug Monitoring Program Data to implement strategies and interventions to prevent NMUPD and examples of this could include sending prescriber or pharmacist report cards to reduce overprescribing and PDMP data can also be used to target patients who might be considered at risk for drug abuse and so Tom is going

to give us an example of how this has been done in Nevada. So, Tom, I'm going to hand over it over to you.

[Tom Clark]: Okay, thank you, Sara. I should mention that the previous case study that I discussed, the one from North Carolina, Project Lazarus. We have a case study written up on that which you can—I think will provide the URL where you can find our case studies and this example from Nevada on Implementation that we also had written up so you can find that there at the same place.

And, what we've got here is an example of how PDMP data can be used to identify at-risk patients and to target interventions with them. This is called then—and actually this is ongoing. It's called the Pre-criminal Intervention Program. Pre-criminal because the intervention is meant to avoid an individual's involvement with criminal justice and I'll show you how that's done. What happens is there is a half-time employee who works with the PDMP, an employee hired by the Board of Pharmacy. The PDMP is run by the Board of Pharmacy in Nevada. And what happens is the PDMP analyzes data and identifies the high-risk patients—for instance, those who are seeing many different providers, many—visiting many pharmacies, multiple provider episodes as we call them, and taking the—those who had the highest rates of doctor shopping, the very highest at-risk patients. Then, contacting their providers. This is what the employee does. The intervention officer is what she is called, although she is not a police officer. She works for the Board of Pharmacy. She will contact first the prescribers to these patients to make sure there is no good medical reason that these patients are involved in what looks like doctor shopping.

Once the prescribers have looked at the data and they've confirmed that, no, there is no good medical reason that this individual should be seeking out these drugs or being prescribed these drugs, then the intervention officer will contact these patients and this is what is unique about—not unique, but important about PDMP data is that you have—you can identify the individual and that you have their address and their name, so using phone books and online computer resources, social media resources, the—the intervention officer is able to make contact with these individuals. She invites them to a meeting at the Board of Pharmacy office, having told them what's—what's—what's involved, and what is involved is she asks them to collaborate with her to help—help them with whatever problems they might have that might be leading them to doctor shopping and the way this works is she has them sign an agreement agreeing to limit their prescriptions to one prescriber and one pharmacy and the—that's the—the carrot is to give them help with their—with their substance abuse issues, find them, perhaps, treatment, get them good medical care, help them with any issues that might have stabilize their situation, but the stick is that if they—if they don't collaborate there is the implicit threat that law enforcement will be contacted because doctor shopping is in fact a felony in Nevada, as it is in many states.

So, the net result is that, of course, these individuals have—have to cooperate. They sign the agreement and then the intervention officer works as pretty much a case management worker to give them or get them the services they need, including any treatment, addiction treatment, or pain management treatment that they might need. So, this is, I think, a very

interesting important application of PDMP data to identify high risk individuals. It's not often done. I think Nevada is one of the few states that is doing this. I think—I'm hoping other states will follow suit because I think it's a very important kind of secondary prevention intervention that takes advantage of PDMP data and I should mention that the behavior of these patients as the intervention proceeds as this case management happens, the behavior is monitored using PDMP data to—so that we can see that, in fact, their doctor shopping stops. So, anyway, that's an interesting application here. Sometimes, often states will send unsolicited reports or alerts about doctor shoppers to prescribers, but they are not doing that much and here is an instance of where the intervention goes beyond the prescriber-patient relationship and it uses a direct contact with the patient to, in this case, avoid any contact with law enforcement, which is an ideal outcome.

Alright, well, with that, I'm going to now turn it back to Sandeep who will talk about evaluations.

[Sandeep Kasat]: Thanks, Tom. There's a question in the chat.

[Tom Clark]: Oh, sure.

[Sandeep Kasat]: So I think Jane asked is there a problem with HIPAA—HIPAA confidentiality here? I'm assuming Jane is asking about the Nevada example.

[Tom Clark]: Sure, yeah. Well, I'm no expert on HIPAA but my understanding is, and really you can correct me, is that PDMP data are not—so long as they are used by prescribers and others involved in patient care that they are—it's okay to share these data—prescription monitoring data, so I think—I'm sure Nevada and I think Oklahoma who is pursuing this has checked to make sure that these—there are no HIPAA violations involved. But that's a great point and certainly that concern has to be addressed in—in conducting such a program.

[Sandeep Kasat]: Yep, thank you, Tom.

[Tom Clark]: Sure.

[Sandeep Kasat]: So, moving onto Step Five: Evaluation, and then it's not surprise that, like, when you are identifying, like, which steps you would use PDMP data for, Assessment was one and Evaluation followed after, because a lot of data sources that you use for Assessment that become the basis for your evaluation and plus some additional data sources that you may need for process evaluation. So, you can use PDMP data to track some of the key risk factors for opioid misuse, like with doctor-pharmacy shopping behavior or higher than normal dose of opioids. Some states are also looking at ways to link PDMP data with other sources, like hospitalization and overdose deaths to track other outcomes as well and one of the biggest strengths of PDMP data, I think, is its timeliness. PDMP—most PDMP upload the data within a couple of weeks which makes PDMP data probably the most real-time data that is out there that we can use for prevention planning and evaluation, as you know, a lot of national surveys annually, some are even biannually and then the other overdose death data probably from CDC and other sources is updated or released

annually after cleaning up, so I think PDMP can be very useful given that it is real-time and I'm going to turn it over to Meelee now to talk about how Florida went about using PDMP data for their evaluation activities.

[Meelee Kim]: Sure. Thanks Sandeep. Okay. So Florida is one of several states that produce an annual report on their PDMP to their legislature and in Florida's evaluation, they use a number of metrics to assess the impact of their PDMP, as well as their policies that are aimed to reduce and prevent nonmedical use of prescription drugs. And we can actually provide some examples of their reports if anyone is interested in seeing them, particularly really about what other measures they are exploring and using but one of the measures that we wanted to highlight for today was the multiple provider episodes, also known as doctor and pharmacy shopping. The Florida PDMP law was passed in 2009, but it actually didn't go into effect until 2011, meaning that's when they first started collecting their data and so we provided just an illustration of the—here, let me just get the arrow here. So, from the time that they started collecting data, which is the last quarter of 2011 to quarter—the second quarter which is end of June of 2016, you can see this downward trend of multiple provider episodes and there—they use this as basically an indicator of how the policies—whether it's at the state or local level are basically affecting the supply and demand of prescription opioids for nonmedical purposes. And so, you know, one of the things to mention here about multiple provider episodes is the definition across the state that the states actually define it somewhat different so here we have these two examples. You see the blue? This is about using a threshold of five or more pharmacies or five or more prescribers and in the red it's using ten or more prescribers and ten or more pharmacies. And so, for example, states that are more rural like, say, Maine will use a different threshold because they will have fewer pharmacies versus those states that are more populated, but in any case I just wanted to mention that about—about how there are differences in the way doctor and pharmacy shopping is defined. But, you see here in Florida that there—they actually had an overall 75% decrease from 2011 to 2016, and so just one measure that states can explore to look at the—look at the evaluation question of are these interventions whether at the state or at the local level and having some sort of an impact?

And, I will hand it over back to Sara who is going to wrap things up.

[Sandeep Kasat]: So, Meelee, I had a question on the previous slide, so can I go back to it one time? So, you mentioned that the multiple provider episode definition—I remember you mentioning the first webinar that could vary from state to state, so is it uncommon—and I know that Florida probably uses the same definition, but is it common or uncommon that, let's say, CDC guidelines or any agency guidelines would change for definition of multiple provider episodes? Is it common or has it—or has that changed over the years as the opioid epidemic became more significant, if you will?

[Meelee Kim]: They have changed somewhat. I think right now there is a consensus, even with the CDC I believe it's five—five or more prescribers and five or more pharmacies within a three-month period would be an appropriate threshold, but, you know, as I mentioned, states need to look at measures that are fitting for their populations, so if you have a rural

state like Maine for example that has fewer pharmacies it would make sense to look at a threshold that would be something like, I don't know, like four or more—no, sorry, four or more prescribers and two or more pharmacies within a three-month threshold to make the indicator work for them. Does that make sense?

[Sandeep Kasat]: Yeah, that totally make sense and I think that's what, like, updating—that's why Oklahoma also sort of tried to adapt the doctor or pharmacy shopping indicator to what made sense for them, so that's a great point, so thank you.

[Sarah Ivan]: Alright, great. Thanks everybody, Meelee and Sandeep. I think we are going to move into taking some questions and comments now. We'd love to have a dialogue with the group about the content that we just presented so if you would like to pose a question or provide a comment, please feel free to write in the chat and we would be happy to take your questions.

And I see one person is typing now, so we will just give her a chance to pose the question.

[Sandeep Kasat]: And I think I'm going to bring back the initial question, Sara, as well. Like if you have plans to use PDMP data in SPF steps in future and if you are taking steps please feel free to chime in and write in the chat box as well, so —

[Sarah Ivan]: Yeah, and I'd like to actually build off of that. If you responded to the poll question earlier, has your response changed do you know? Do you see things differently now that we've gone through some of this content and how—how do you think you could use it?

[Sandeep Kasat]: Makes total sense.

[Sarah Ivan]: Alright, so we will just give you a couple of minutes to—to ponder those questions and think about any other questions you might want to—to pose while we have our experts on the line and I see Lajeane: "Tessa, can you share the insurance provider who helped with the funding? How difficult was this collaboration?" So, Theresa, if you could write your response in the chat that would be great and I see one more person is typing. We will just wait while we have multiple attendees typing. We can move on with your conversation.

Alright. And Tessa says that, "The collaborator was someone already working on a community coalition targeting foster care issues, so we could make a connection about the idea and she forwarded us onto the correct contacts." And, Lajeane, just let us know if that's helpful. And, I see another comment.

Sumar says, "I think using PDMP data at the capacity building stage to generate a sense of urgency to address the issue among stakeholders is a fantastic strategy. Had not considered that at this stage." Thanks, Sumar, for your comment. Does anybody else feel this way or think that there are other places where you'd fit PDMP data into the SPF process? Please feel free to let us know.

And Tessa says, "I think insurance companies are a lot more willing to work on this than I had previous thought. A cold call would probably be well-received." Thanks Tessa. I see Meghan has a comment. She is typing. We will wait for you to—to respond, Meghan. And anybody else who has a comment—I think Sumar had a really great point about capacity building to generate that sense of urgency to address issues among stakeholders and really build this—this urgency for the issue that is going—going on right now is helpful and we can use data to help make this a priority within our communities.

[Sandeep Kasat]: So, Tom and Meelee, while we wait for the comment in the chat box, one of the questions I had for you is regarding the patient ID number—unique ID, and I remember you guys mentioning in the first webinar that not all PDMPs actually have unique identifiers and some of them are working on it and then probably that's one of the ways of linking PDMP data to other data sources. Is that correct?

[Tom Clark]: There—yeah, there are lots of—there are given approaches to identifying unique patients in PDMPs. There is no single best way to do it. Some—some use probabilistic matching and some use deterministic matching. California recently has changed the way it's identified its patients in this PDMP data. Now, we are able to—we are actually looking at how the two different approaches compare. The data aren't in yet, but it's a project we are working on to see if the new system actually does a better job of identifying unique individuals in PDMP data and, and as you say, Sandeep, that kind of identification is critical when it comes to linking patient data across—PDMP data with other health data or death data for instance, so it's a very important issue. We are hoping that this kind of patient identification will improve because we do want to make sure ideally that we are dealing with a single unique individual when we are talking about, say, a doctor shopper or someone who might be overprescribed to, that kind of thing. Yeah, it's an important issue.

[Sandeep Kasat]: Yep. That makes sense. Thank you.

[Meelee Kim]: Yeah, but just to clarify, the PDMP itself doesn't have a unique patient number. Say, you can generate a unique patient number for research purposes or surveillance purposes—public health surveillance I should say. But there is no patient unique number.

[Tom Clark]: Right. Thank you, Meelee. You are absolutely right. I—the State of Kentucky actually uses a social security number in the PDMP record, interestingly enough. I don't know if—how many other states do that. Some other states I think use driver's licenses, but it—but, of course, there are all—there can be data entry issues and entry mistakes, so even if you—even a social security number isn't—isn't foolproof and of course some states—some people might worry about a social security number being in a public—in a database potentially hackable, so it's always going to be a problem. But, yeah, Meelee's correct. There is no unique patient identifier that PDMPs have.

[Sarah Ivan]: Thanks Tom and Meelee. We have another comment from Jean and she says, "I'm very concerned about the precedent of releasing personal health insurance to

non-providers even though their intent is to intervene for the patient's welfare. This could open the door to accessing other healthcare information." And, Meelee and Tom, would you—either of you be able to comment on that issue?

[Tom Clark]: Well, yeah, this is certainly a concern and I think getting back to the Nevada case study. The—the medical—you know, doctor shopping is a felony in—or at least a crime in most states and there is evidence to support that then law enforcement actually has a mandate to look into it, so what happened is that the prescribers were contacted. This is the—those are—very first important step to make sure that there was no medically legitimate reason for this—for this prescribing and the prescribers actually signed affidavits to the effect there was no medically appropriate use or reason for this receiving drugs from multiple prescribers. So that—that's sort of the—the basis for pursuing it outside of the doctor/patient relationship is that—is that there are laws against doctor shopping, of knowingly being prescribed drugs that you—you are not using medically. So, but it is not to discount that concern that—that was raised, so—yeah. All due care and due process has to be pursued to make sure this kind of intervention is above board. It doesn't violate HIPAA or other patient confidentiality or health—or health—or health protections, so it's a great point.

[Sandeep Kasat]: And, then Tom, though, the example we showed on this PowerPoint presentation and also looking at PBSF state data I think a lot of folks in prevention are using the aggregated data, right? Even though you have access to patient identifier they are actually aggregating data by age, gender, and county level so that they—they can look at like the—this broad subgroups of data and identify at-risk populations so that they can direct prevention programs so—and I know that especially in Oklahoma they are doing that, that even though they have access to the information, health information and confidential information, they are actually only using aggregated data for selecting prevention programs, if you will, but your point also, Tom, is well-taken. If you want to identify doctor or pharmacy shopping and if it's a felony in your state, so the purpose of DEA or regulatory agency will be different but mostly for prevention providers we are looking at aggregated data by age or any other subgroup or county if you will.

[Tom Clark]: You are absolutely right. The other thing though, in terms of identifying specific patients is an important prevention measure I think is to encourage states that if they are not already doing so to have—to issue unsolicited reports and alerts from the PDMP that go to the provider that does involve patient information, but it is kept within the doctor-patient relationship, so if your state is not doing unsolicited reports or alerts that to me would be an important thing for stakeholders to—to work on, to make sure that that happens, but you are right, Sandeep, for most primary prevention it's going to be aggregated data that's going to be used by—by prevention programs.

[Sarah Ivan]: So, switching gears a little bit, we have another comment in the chat and it seems like this would be easier with law—PDMPs being managed by law enforcement versus Board of Pharmacy. Do you have any comments Meelee, Tom or Sandeep about this law enforcement versus pharmacy management style? I know that it—it varies per state, so I'm sure that you've seen—seen both ends of the spectrum.

[Meelee Kim]: Tom, do you want to start?

[Tom Clark]: Meelee, I thought you had a good response to that. I thought—I think I saw you write a response to that.

[Meelee Kim]: Yeah. So, yeah, so there has actually been a lot of speculation about, as you say, management style of state PDMPs, you know, depending on where it's housed. You know, with the—with the Department of Public Health versus the Board of Pharmacy versus a law enforcement agency and what we've found is that it really doesn't matter where the PDMP is housed. What really matters are the resources that the PDMP has. So, for example, Nevada, where they actually have this intervention officer. It's actually managed by the Board of Pharmacy and they've taken a very—I don't want to say a law enforcement style to their management, but they were the first state to—to come up with this intervention where they are trying to get people into treatment and then you have a state like, let's see, Oklahoma, for example, which is housed in a law enforcement agency and they are doing some of the most innovative public health intervention in the country so, yeah, I'd like to try to dispel the myth that where the—the PDMP is housed actually matters about, you know, how innovative or effective they are.

[Tom Clark]: Yeah, the big difference is how well-supported the PDMP is. The kind of funding, staff and resources made available to it, not the agency that houses it.

[Sarah Ivan]: Thanks Meelee and Tom. And I see we have another question. I think this might be better directed at me and Sandeep. "Is there one statement for each SPF step that will help guide how we consider the PDMP data? For example, under capacity building is it sharing data to motivate stakeholders to take action? How would you describe the other steps? Some steps seem redundant and confusing." Sandeep, do you want to give a crack at it first?

[Sandeep Kasat]: Yeah, I mean, that's a really, really good point. One of the things I will definitely mention that the SPF step . . . SPF is a cyclical model and then I know that there are steps that—let's say your epidemiological workgroup or state advisory council, your evaluator is taking at the same time and also one step sort of feeds into another and then there are these simultaneous steps that are happening as well, so, Carol, your point is very well-taken. What we will definitely do is actually make sure that we be clear in terms of how—how similar under each SPF step the PDMP data can be used and how it could be different under each of the steps so I think our purpose here was sort of to show that Assessment sort of can be used in needs assessment but if you look at Evaluation, similar data can also be used for evaluation purposes so I think what we need to do at the CAPT is basically point out how PDMP data specifically can be used for assessment purposes and then you will take the same data and sort of identify steps that you would probably take for the evaluation. I think maybe that would help so, so I think that's like sort of some homework for us and we are all learning from Meelee and Tom and others—you all as well, and then developing this understanding of the PDMP data so that is a great point and I think that's a pointer for us to whenever we release something related to PDMP data we'll definitely be

clear in terms of how, or be more specific, in terms of how it can be used under each of the SPF steps.

Does that sort of address your concern, Carol? I know that, like, when you look at these presentations there is a significant overlap in the SPF steps and that was sort of our purpose to see how PDMP data can fit under each step, but I think what you are asking for, like, what specific actions would you take with the PDMP data so that you are clear in terms of what you will do with PDMP data under each step. Does that make sense? So, I think we can follow up with you on that and then we will be clear when we release something else—or we can take this on in the third webinar series as well.

[Sarah Ivan]: Yeah, and I agree with Sandeep. I think this is an opportunity for the CAPT to also come back and provide a little bit more information, although we did prepare a handout after this webinar providing some of the examples that we've gone through today per SPF steps so hopefully that will also be helpful to you and we are going to provide that in a download box on the webinar today so —

[Sandeep Kasat]: And I made note that, like, when we did—like what we present in the third webinar we'll definitely present like one statement under each of the SPF steps that we can take, like, so clear and concise statement with the SPF steps in a —

[Sarah Ivan]: Absolutely.

[Sandeep Kasat]: —form of table or one slide if you will when —

[Sarah Ivan]: Absolutely.

[Sandeep Kasat]: —we present the third webinar.

[Sarah Ivan]: Okay, great. And I see we have another question that came through. "How do people get communities to understand MMEs?" Meelee and Tom, what have you seen in the field and with your work and PDMPs?

[Tom Clark]: Well, an MME or MED is the morphine milligram equivalent. It says if you are given different types of opioids what the—what the actual dose would be in—and if you were just taking morphine per day and so the research—there has research that has been done on daily opioid dose as a risk factor for overdose and death. Research is ongoing still, but the—I think the basic message to the community is that if you are on a high opioid dose for any length of time you are—you really—your risk for overdose and, perhaps, death does increase by a factor of, I don't know, five to ten perhaps. The research varies a bit, but it's a significant increase in risk so I've—I think that's the—the message for the general public that high opioid dose is a risk factor. So, if you are not being treated for cancer or other terminal illness or something like that then you—you don't want to stay on a high opioid dose for very long at all. Avoid it if possible. I hope that answered the question and didn't go too—too far off—off base on that.

[Sarah Ivan]: Let us know if that didn't answer their question, Karen. And, Karen asked, "What is a high dose?"—to Tom.

[Tom Clark]: Well, yeah, as I think I suggested, and Meelee had mentioned before, the—one of the standard risk thresholds is either 100 or 90 morphine milligram equivalents for a daily dose, so 90 mg of morphine—if you are taking more than that per day or any equivalent dose of opioids then that's—that's the threshold over which, for instance, some PDMPs recommend that to prescribers that you also prescribe naloxone to go along with that prescription, because you are at risk for overdose. So high dose would be at least 90 or over.

[Sarah Ivan]: Alright, thanks Tom.

[Meelee Kim]: Maybe—I think it's fair to also mention that states also have different thresholds for—you know, different determinations for what they would consider high dosage—ideally dosage, so there are some states that have public campaign focused, like—what was it called? Go Slow and Go Low, so it was like—you know, start low dosages and go slow if you are going to increase the dosage—the daily dosage and so some states, you know, have been having as low as six daily milligram morphine equivalents so, you know, the CDC has put their foot down and said that they think patients should not be given more than 90 milligram morphine equivalents, but some [states?] I think wanting that threshold to be a lot lower. I hope that kind of, you know, kind of explains—you know, it sort of depends on the community.

[Sarah Ivan]: Alright. Does anybody else have any questions or comments while we have our—our presenters on the line? I will just give you a couple of minutes and think of any last minute questions that you might have. I think we've covered a lot today so if anything comes up afterwards we will definitely be providing contact information. You can contact me and I can get you in contact with the right person.

Yep, and as I said, if you do have any other questions or comments after today's webinar, please don't hesitate to contact me and my email address is included on the slide and we thank you so much for participating in today's webinar. And please take a moment also to respond to our evaluation and your feedback is extremely important to us. We can leave this link up on the webinar for a few minutes for you to complete, and thank you. Have a wonderful rest of your day.

REFERENCES

1. Paulozzi, Leonard J., Strickler, Gail K., Kreiner, Peter W., and Koris, Caitlin M. (2015). Controlled Substance Prescribing Patterns-Prescription Behavior Surveillance System, Eight States, 2013. *CDC's Morbidity and Mortality Weekly Report*. From http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6409a1.htm?s_cid=ss6409a1_w
2. PDMP Training and Technical Assistance Program. (n/d). PDMP Maps and Tables. <http://www.pdmpassist.org/content/pdmp-maps-and-tables>.
3. PDMP Training and Technical Assistance Program. (2016). PDMPs Authorized and Engaged in Sending Solicited and Unsolicited Reports to Health Care Providers and Patients. http://www.pdmpassist.org/pdf/Health_Care_Entity_Table.pdf
4. PDMP Training and Technical Assistance Program. (2016). Release of PDMP Data for Research, Epidemiological, or Educational Purposes. http://www.pdmpassist.org/pdf/Data_Use_Res_Epi_Educ.pdf
5. PDMP Training and Technical Assistance Center. (2016). PDMP Prescriber Use Mandates: Characteristics, Current Status, and Outcomes in Selected States. http://www.pdmpassist.org/pdf/COE_documents/Add_to_TTAC/COE%20briefing%20on%20mandates%203rd%20revision.pdf
6. Electronic-Florida Online Reporting of Controlled Substances Evaluation (EFORCSE). (2016). 2015-2016 Prescription Drug Monitoring Program Annual Report. <http://www.floridahealth.gov/statistics-and-data/e-forcse/documents/2016PDMPAnnualReport.pdf>